North Dakota Child Fatality Review Panel

2005 Annual Report

North Dakota Department of Human Services
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Table of Contents

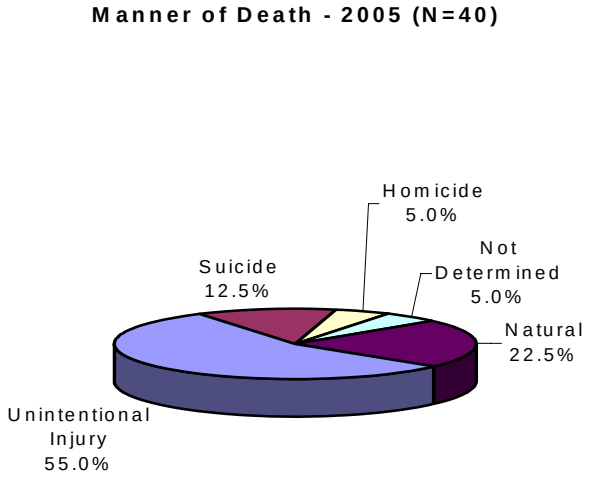
North Dakota Child Fatality Review Panel
2005 Executive Summary

The North Dakota Child Fatality Review Panel (NDCFRP) fulfilled the duties mandated by the North Dakota Century Code during 2005. By statute (50-25.1-01), the Panel is charged with responsibility for "the identifying of the cause of children's deaths, where possible; the identifying of those circumstances that contribute to children's deaths; and the recommending of changes in policy, practices, and law to prevent children's deaths". Additionally, the Panel is to "meet at least semiannually to review the deaths of all minors which occurred in the state during the preceding six months and to identify trends or patterns in the deaths of minors. (NDCC50-25.1-04.3)"

The Panel met on a quarterly basis during 2005 and completed the following number of reviews:

Calendar Year 2005	
Total Child Deaths (From all causes)	**94**
Status B Deaths Status B cases are deaths that are not unexpected (i.e. long term illness) and/or deaths that are due to natural causes. (Review of Death Certificate only)	**48**
Status A Deaths Status A cases consist of all cases of children whose death is sudden, unexpected, and/or unexplained.	**46**
Out-of-State Child Deaths The "death-causing" event/injury is identified as occurring outside of North Dakota. (Not reviewed in depth by the NDCFRP.)	**6**
In-State Child Deaths All other child deaths with North Dakota death certificates. (Reviewed in depth by the NDCFRP.	**40**

After an in-depth review, the Child Fatality Review Panel either agrees or disagrees with the manner of death indicated on each death certificate. When the Panel, after an in depth review, does not agree with the manner of death indicated on each death certificate, the Panel reclassifies the manner of death for its own purposes. The Panel's classifications serve as the basis of this report. **The Panel reclassified three deaths in 2005.** The manner of death on one death certificate was not completed. The Panel classified this death as "accident". One death was re-classified from "Natural" to "Accident", due to the child choking on food. One death was re-classified from "Natural" to "Undetermined" due to the lack of a death scene investigation. The Panel's classifications of the manner of death for 2005 is represented in the chart to the right:



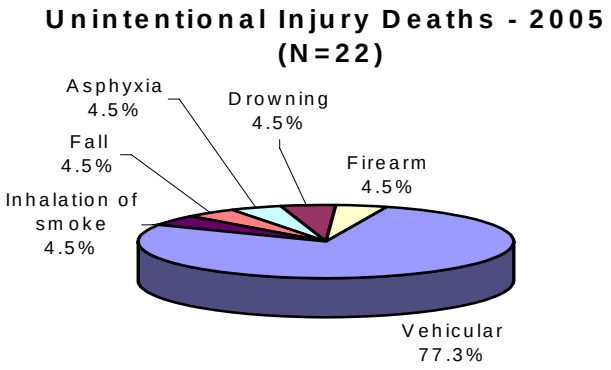
2005 TRENDS

The Panel identified that Native American children are over represented in the Child Fatality numbers. According to North Dakota Kids Count for 2004, North Dakota's child population is 85% Caucasian, and 9.0% Native American. However, 11 of the 40 (27.5%) deaths reviewed by the North Dakota CFRP during 2005 were Native American children.

Of the 40 deaths reviewed in-depth, 32.5% (n=thirteen) were ages 0-2 years; 5% (n=two) were ages 3-5 years; 17.5% (n=seven) were ages 6-8 years; 2.5% (n=one) was age 9-11 years; 10% (n=four) were ages 12-14, and 32.5% (n=thirteen) were ages 15-17. These numbers indicate children at greatest risk of death are the very young and our teenagers.

Unintentional Injury Deaths

Unintentional injury is the largest category of child deaths for 2005. Unintentional Injury Deaths are commonly referred to as accidents, both by the public and by the manner of death as recorded on death certificates. However, the term "accident" implies that the fatal injury/event could not have been prevented. Therefore, the Child Fatality Review Panel prefers the term Unintentional Injury as opposed to the term accident because the child deaths in this category are predictable, understandable, and preventable. In fact, the Child Fatality Review Panel classified all 22 unintentional injury deaths as preventable.



The largest sub-category of unintentional injury death is vehicular, accounting for 17 of the 22 child deaths from all unintentional injuries in 2005. The deceased child was the driver in eight of the vehicular deaths and a passenger in nine of the deaths. Two of the children were bicycle riders. One child was a pedestrian. Out of the vehicular deaths in 2005, eight involved single vehicles and nine involved two vehicles. Of the eight deaths involving single vehicles, five were rollover crashes. In the cases where use of a vehicle restraint applies, four of the children who died were not restrained. The use of safety restraints was not applicable to seven child deaths (e.g. a safety restraint would not have been required in the situation). The use of safety restraints is unknown in four of the deaths. Six children were ejected from the vehicle. Ejection did not apply in six deaths. (Ejection does not apply to vehicles that are not enclosed e.g. bicycles, ATVs, etc.). Excessive speed or recklessness was a factor in three deaths. Driver intoxication was a contributing factor in one death, while underage drinking was found in two deaths. Other contributing factors include: driver distraction (6); failure to yield (4); young bicycle riders (2 -ages 4 and 6 years); young ATV drivers (2 - ages 6 and 8 years); unlicensed driver (1 - age 16).

There were five deaths from other unintentional injuries in 2005. There was one unintentional injury death from drowning, one unintentional death from a firearm, and one death from asphyxia related to choking and one death from inhalation of smoke in an apartment fire.

Natural Deaths

The manner of death was classified as natural for nine (22.5%) of the 40 child deaths reviewed in 2005. One of the deaths in this category was determined by the Panel to have been preventable if an appropriate disease management plan had been in place. Six babies died from SIDS (Sudden Infant Death Syndrome). Three natural deaths did not fall into one of the other identified types of fatal injury/event data categories. There was no autopsy completed in one case of the natural deaths. All the other children in the category of natural deaths received an autopsy.

Suicide Deaths

There were five suicide deaths in children during calendar year 2005.

Homicide Deaths

In 2005, two children died as the result of homicide.

Deaths Where the Manner Could Not Be Determined

The Panel could not determine the manner of death for two deaths in 2005. In one case, risk factors for SIDS could not be ruled out. One of these two deaths did not have an investigation of the death scene.

CHALLENGES:

Investigations of Children's Deaths

- Death scene investigations were below a satisfactory standard in four 2005 deaths
  - Many child death investigations do not include interviews with the parents and others who live in the home or who were present in the home at the time of the death.
- Investigations of traffic fatalities involving children often do not include alcohol testing of the child or of the vehicle's driver
  - Excluding this testing may mask the pervasiveness of alcohol related fatalities.

Interagency Communication

- Interdisciplinary failure to properly report child deaths promptly to appropriate authorities was identified in one death in 2005.
  - Failure to report can result in lost evidence and failure to address services needed by families

Access to records

- North Dakota law (NDCC 50-25.1-04.4) provides that specific information be provided to the Panel upon request. This statute also mandates that law enforcement, courts, and agencies cooperate in fulfilling the purpose of the statute (NDCC 50-25.1-12)
  - Regardless of these mandates, information is too often not forthcoming in response to Panel requests.
  - When this occurs, the Panel's statutory mandate (NDCC 50-25.1-04.3) to review the deaths of all minors is greatly hindered.
  - The Panel has no investigatory authority of its own and is completely dependent on the work and cooperation of partner agencies

- An additional barrier concerns entities outside the jurisdiction of state statues. These entities are not compelled to share information with the Panel.
    - Federal agencies, such as the Federal Bureau of Investigation and the Bureau of Indian Affairs are not compelled to share information with the Panel
    - Tribal governmental agencies, such as tribal child welfare and tribal law enforcement, are not compelled to share information with the Panel.
- The lack of access to investigation records was identified as an obstacle to effective child fatality reviews in three cases in 2005

PANEL RECOMMENDATIONS

- The Panel recommends that blood alcohol testing be conducted in all traffic fatalities involving children.
- The Panel will continue to promote increased statewide quality of child death investigations and interagency communication.
- The Panel, with interagency support, must continue to promote increased cooperation among professional disciplines across all jurisdictions.

LONG TERM TRENDS

Child Deaths by Year:

Year	Total child deaths	Number reviewed in depth
1996	103	55
1997	109	51
1998	123	59
1999	116	54
2000	109	38
2001	98	43
2002	93	35
2003	107	38
2004	87	39
2005	94	40

Vehicular Deaths by Year:

Year	Vehicular deaths
1996	16
1997	18
1998	18
1999	17
2000	13
2001	15
2002	11
2003	16
2004	15
2005	17

SIDS Deaths by Year:

Year	SIDS Deaths
1996	5
1997	10
1998	10
1999	10
2000	9
2001	8
2002	8
2003	3
2004	2
2005	6

Suicide Deaths by Year:

Year	Suicide Deaths
1996	11
1997	7
1998	4
1999	8
2000	6
2001	5
2002	2
2003	3
2004	5
2005	5

Homicide Deaths by Year:

Year	Homicide deaths
1996	0
1997	0
1998	2
1999	1
2000	1
2001	1
2002	2
2003	4
2004	3
2005	2

According to North Dakota Kids Count, the North Dakota child population continues to decline. There were 137,998 in 2005, a 14.2 percent decline from 160,849 in 2000.The numbers related to child deaths in our state seem to reflect this population trend, showing corresponding decreases in the total number of child deaths (109 child deaths in 2000 to 94 child deaths in 2005). However, despite the decrease, areas of concern remain.

The numbers of vehicular crash deaths appear to be remaining steady over the last ten years, with an average of 15 crash deaths per year (17 in 2005). Even though the numbers of crash deaths may not seem large when compared with deaths in more populated states, vehicular deaths have remained the primary cause of child fatalities North Dakota for the last ten years.

There is also concern about the numbers of SIDS deaths. SIDS deaths have averaged seven deaths per year over the past ten years (6 in 2005). Numerous risk factors for SIDS are identified in too many of these cases. Research over this same period of time indicates a reduction in the identified risk factors is associated in a corresponding reduction in the number of SIDS deaths.

The Panel finds the number of youth succumbing to suicides very troubling. Child deaths from suicide have averaged five per year over the past 10 years (5 in 2005). Although research reports a reduction in North Dakota's suicide rate in the 10-24 year-old age group, this does not appear to be true for the 0-18 year-old population.

Although the number of North Dakota children who die as the result of homicide may not seem large (2 in 2005) and an increase in the number of these deaths does not yet appear to be a trend; nonetheless, the Panel finds these child homicides disturbing.

Purpose and Goals

The North Dakota Child Fatality Review Panel reviews deaths of all children (under 18 years of age), which occur in the state. By sharing information and reviewing data, panel members review the circumstances surrounding the deaths and look for patterns or trends to identify possible prevention strategies.

Purpose of the Child Fatality Review Panel

- Identify the cause of children's deaths
- Identify circumstances that contribute to children's deaths
- Recommend changes in policy, practices, and law to prevent children's deaths

Goals of the Child Fatality Review Panel

- Accurate identification and documentation of the cause of death
- Collection of uniform and accurate statistics
- Coordination among participating agencies
- Improvement of criminal investigations and prosecution of child abuse homicides
- Protocols for investigation of certain categories of child deaths
- Identification of any changes needed in legislation, policy, practice, and/or training
- Use of media to educate the public about child fatality prevention
- Intercounty and interstate communications regarding child deaths
- Development of local child fatality review panels
- Evaluation of the impact of specific risk factors on child deaths including substance abuse and domestic violence

Strategies have been identified in North Dakota, and nationally, that will improve reporting of child deaths, death certification, and training for professionals responding to child fatalities. The following are areas of strategy development:

1. **Law Enforcement –** establishment of uniform child death scene and death investigation protocols

2. **State Forensic Examiner/Coroners –** improved access to, technical assistance, and thorough autopsies

3. **Public Health –** implementation of primary prevention programs focused on education and awareness campaigns such as "Back to Sleep", "Never Shake a Baby", safety programs for firearms, seat belts, child restraint, fire and poison prevention

4. **Social and Mental Health Services –** supportive services for surviving family members and communities

Panel Membership
(NDCC 50-25.1-04.2)

The Child Fatality Review Panel is a multidisciplinary, multi-agency, appointed panel. Each panel member serves as a liaison to their professional counterparts, provides definitions of their profession's terminology, interprets the procedures and policies for their agency and provides information from their records.

North Dakota State Child Protection Team (Core Membership)

- Designee of the Department of Human Services who serves as the presiding officer
- Representative of a child placing agency
- Representative of the North Dakota Department of Health
- Representative of the North Dakota Attorney General's office
- Representative of the North Dakota Department of Public Instruction
- Representative of the North Dakota Department of Corrections
- Representative of the lay community

Other Appointed Members

- State Forensic Examiner
- North Dakota Licensed Peace Officer
- Mental Health Professional
- A Physician
- North Dakota Injury Prevention – Department of Health
- Emergency Medical Services– Department of Health
- Consultants invited to assist in review of a specific case

Child Fatality Review Panel members agree that no single agency or group working alone can determine how and why a child has died. The shared commitment is to work together to improve agency and community responses to child deaths and to identify prevention initiatives.

Panel Members – 2005

Gladys Cairns – CFRP Presiding Officer
Administrator, Child Protection Services – DHS

Shelly Arnold - DEMS
ND Department of Health

Marlys Baker – CFRP Administrator
Child Protection Services – DHS

Karin Bartoszuk
NDSU Extension Service

Jonathan Byers
Assistant ND Attorney General

Tom Dahl
ND Bureau of Criminal Investigation

Dr. Terry Dwelle – State Health Officer
ND Department of Health

Warren Emmer - Parole & Probation
ND Department of Corrections

Karen Eisenhardt - Educator
State Child Protection Team – lay member

Steve Kukowski
Minot Police Department

Dr. Gordon Leingang - Emergency Trauma
St. Alexius Medical Center

Carol Meidinger - Injury Prevention Program
ND Department of Health

Dr. Ron H. Miller
MeritCare Children's Hospital

Dr. George Mizell
State Forensic Examiner

Carla Pine
Burleigh County Social Services

Bob Rutten
Department of Public Instruction

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Introduction

History

The North Dakota Child Fatality Review Panel was established by North Dakota Century Code 50-25.1 and began reviewing child deaths in 1996. By law, the purpose of the NDCFRP is: "the identifying of the cause of children's deaths, the identifying of those circumstances that contribute to children's deaths; and the recommending of changes in policy, practices, and law to prevent children's deaths."

The Panel presents all of these issues to the public for attention.

Lessons Learned

The most important lesson learned from the Panel's reviews is that **many child deaths each year are preventable and that every citizen can play a role in reducing child fatalities.**

Preventability of death

In determining the reasons for preventable deaths, the Panel is not seeking to place blame, but rather, pointing the way toward preventing future deaths.

The majority of preventable child deaths reviewed by the Panel in 2005 occurred as a result of **unintentional injuries**. The majority of these deaths (10 of 22; 45%) occurred among children ages 12 to 17. Over two-thirds of the unintentional injury deaths (17 of the 22; 77%, including 12 motor vehicle related deaths) are determined to be caused by reckless conduct of others. Most of the preventable deaths (17 of 22; 77%) are motor vehicle related deaths. As we study the circumstances of these tragedies, we learn that more effective social marketing and education focused on safety concepts and injury prevention are needed to reach parents and teens. Currently, laws are in effect which mandate graduated driver's licensing and safety restraint use. Safety and seat belt campaigns have been provided. However, driver education courses offered in the public schools have decreased as schools struggle with resource concerns. Societal issues such as underage alcohol usage (2 in 2005), excessive speed (3 in 2005), and failure to use seat belts contributed to 4 of the 17 vehicle related deaths in 2005. Issues such as driver distraction (6 in 2005), young drivers of ATVs (2 - ages 6 and 8 years in 2005) and the supervision of young bicycle riders (2 - ages 4 and 6 years in 2005) are issues not addressed by current strategies.

Sudden Infant Death Syndrome (6 in 2005) claimed the second largest number of North Dakota children in 2005. While SIDS is still largely considered non-preventable, there are a number of risk factors present in all of these 2005 deaths, which if eliminated, have been shown to reduce the number of deaths from SIDS. Prevention information in the hands of parents, childcare providers and family caregivers has the potential to impact the number of SIDS deaths in our state.

The number of **teen suicide** deaths in our state (five in 2005) continues to be disturbing. These suicides highlight the need for more accessible mental health care for adolescents, particularly in schools and on the state's Indian Reservations. Other strategies for prevention include education for parents, friends and family members of adolescents on the signs and symptoms of depression, the risk factors for suicide, and the factors that may protect teens from suicide. This education needs to include information on how to access community mental health resources if someone is concerned about an adolescent.

Continuing Challenges for the Child Fatality Review Panel

Among the duties assigned to the North Dakota Child Fatality Review Panel by state law are the promotion of:

- Interagency communication for the management of child death cases and for the management of future nonfatal cases;
- Effective criminal, civil, and social intervention for families with fatalities;
- Interagency use of cases to audit the total health and social service systems and to minimize misclassification of cause of death;
- Evaluation of the impact of specific risk factors including substance abuse, domestic violence, and prior child abuse; and
- Intercounty and interstate communications regarding child death.

The Panel identifies the following as ongoing challenges in accomplishing these assigned duties:

Investigations of Children's Deaths

The Panel continues to be concerned about the quality of child death scene investigations. Even though there has been some observable increase in the quality of scene investigation in cases of infant death since the inception of the Panel, too many scene investigations remain below a satisfactory standard. Many child death investigations do not include interviews with the parents and others who live in the home or who were present in the home at the time of the death. **Information in this report that is presented as "unknown" is often the result of information not gathered during a death scene investigation.**

The death investigations of some child deaths continue to be minimal. Investigations do not always explore circumstances leading up to the death or are not comprehensive enough to uncover information vital to identifying the cause and manner of death or in identifying risk factors and formulating effective interventions. The thoroughness of child death investigations varies greatly. **Information regarding the child and family history, abuse, violence, alcohol and drug use, mental health issues, domestic violence and other such issues are vital** to understanding the circumstances surrounding the deaths of children and for planning to prevent future deaths, yet this is the very information that is often not gathered or not recorded in an investigation.

The Panel has also become concerned that child victims of traffic fatalities too often are not identified as coroner cases and an autopsy is not performed. According to state law, any person who acquires the first knowledge of the death of any minor, when the minor died suddenly when in apparent good health, shall immediately notify law enforcement and the office of coroner of the known facts concerning the time, place, manner, and circumstances of the death (NDCC 11-19.1-07). **There are four deaths identified in 2005 in which children who died in automobile crashes where county coroners were not contacted and there was no autopsy performed.**

The Panel recommends that autopsies be performed for all child fatalities that are coroner's cases, including child deaths resulting from motor vehicle crashes.

Interagency Communication

Interagency communication regarding child deaths needs to be improved, particularly requirements for reporting child deaths across systems. Failure to report these deaths promptly to appropriate authorities can result in families failing to receive needed services and lost evidence. Interdisciplinary failure to properly report was identified in one death in 2005.

The Panel will continue to find ways to promote increased statewide quality of child death investigations and interagency communication.

Access to records

The Panel's ability to access relevant records for review remained of concern in 2005.

North Dakota law (NDCC 50-25.1-04.4) provides that, "Upon the request of a coroner or the presiding officer of a child fatality review panel, any hospital, physician, medical professional, medical facility, mental health professional, or mental health facility shall disclose all records of that entity with respect to any child who has or is eligible to receive a certificate of live birth and who has died". This statute also states, "All law enforcement officials, courts of competent jurisdiction, and appropriate state agencies shall cooperate in fulfillment of the purposes of this chapter" (NDCC 50-25.1-12).

Regardless of these mandates, information is too often not forthcoming in response to Panel requests. When this occurs, the Panel's statutory mandate to, "review the deaths of all minors which occurred in the state during the preceding six months and to identify trends or patterns in the deaths of minors (NDCC 50-25.1-04.3) is greatly hindered. The Panel has no investigatory authority of its own and is completely dependent on the work and cooperation of the agencies with this authority.

There are also other entities in possession of detailed and valuable information about a given child, whose records are not addressed in state law. If not provided by request, these records remain inaccessible to the Panel. These records frequently include school records, and records of substance abuse treatment professionals.

An additional barrier identified by the Panel concerns governmental entities that are outside the jurisdiction of state statues. These governmental bodies are not compelled to share information with the Panel. This includes federal agencies such as the Federal Bureau of Investigation and the Bureau of Indian Affairs Law Enforcement, and tribal governmental agencies, such as tribal child welfare and tribal law enforcement. While many tribal governmental entities offer some support for the work of the Panel, it is a concern that federal records remain inaccessible. The lack of access to investigation records was identified as an obstacle to effective child fatality reviews in three cases in 2005.

The Panel, with interagency support, must continue to find ways to promote increased cooperation among professional disciplines across all jurisdictions.

Calendar Year 2005

Overview

Overview

General Procedure

The North Dakota Department of Health provides vital statistic records for each child who has died in North Dakota. North Dakota Century Code Health Statistics Act (NDCC 23-02.1) allows for the release of vital records information to the Child Fatality Review Panel (23-02.1-27 "Disclosure of records").

The Child Fatality Review Panel Presiding Officer is allowed under NDCC 50-25.1-04.4 to request and receive records from any hospital, physician, medical professional, medical facility, mental health professional, mental health facility, law enforcement or social services. These entities are required to disclose all records requested by the Child Fatality Review Panel.

Case specific information is requested by the presiding officer and prepared for review by the Administrator of the Child Fatality Review Panel. The Child Fatality Review Panel meets on a regular basis, at which time the compiled information is presented to Panel members for discussion. A determination of the Panel's agreement as to the manner of death indicated on the death certificate and the preventability of death are determined by a consensus of the Panel members. A data form is maintained for each case reviewed to document panel findings and recommendations. This data form is used in compiling non-identifying, death related information that serves as the basis for this annual report. Meetings are closed to the public and all case discussions and documents, except for this annual report, are confidential by law (NDCC 50-25.1-04.5).

Case Status

Each death certificate received from the Department of Health is reviewed by a Child Fatality Review Panel subcommittee; each death is identified as a Status A case or a Status B case. A status A case consists of all cases of children whose death is sudden, unexpected, and/or unexplained, including natural deaths. Status A cases receive an in-depth, comprehensive review and are included in the analysis in this report. Status B cases are deaths that are not unexpected (i.e. long term illness) and/or deaths that are due to other natural causes. Status B cases are only presented for review by the Child Fatality Review Panel in a brief, general format in order to give all Child Fatality Review Panel members an opportunity to request that the case be changed from Status B to Status A. If no member requests a change in status, the death remains Status B and the data is not included in this report.

2005	
Total Child Deaths	**94**
Status B Deaths	**48**
Status A Deaths	**46**

In-State and Out-of-State Child Deaths

When the "death-causing" event/injury is identified as occurring outside of the state the death is considered an out-of-state child death, even though a North Dakota death certificate is issued. All other child deaths with North Dakota death certificates are considered in-state child deaths. Both out-of-state child deaths and in-state child deaths are reviewed by the Child Fatality Review Panel, but only in-state child deaths are used for the analysis in this report.

2005 "Status A" Child Deaths	
Total Status A Child Deaths	**46**
Out-of-State Child Deaths	**6**
In-State Child Deaths	**40**

Overview (continued)

Manner of Death

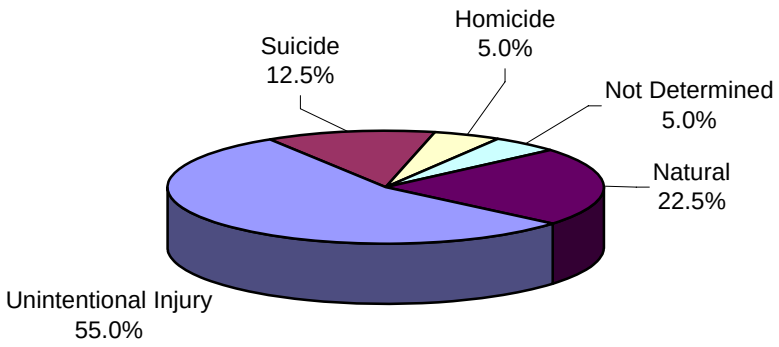
North Dakota Death Certificates list the following five manners of death: "Natural", "Accident", "Suicide", "Homicide", or "Could Not Be Determined". After an in-depth review of each case, the Child Fatality Review Panel either agrees or disagrees with the manner of death indicated on each death certificate. If the Child Fatality Review Panel agrees, the manner of death listed on the death certificate is recorded as the Child Fatality Review Panel manner of death. However, if the Review Panel disagrees, the Panel reclassifies the manner of death for its own purposes. It is the Panel's classifications that serve as the basis of this report.

The Panel reclassified three deaths in 2005. The death certificate was incomplete in one case. The manner of death was not completed. The Panel classified this death as "accident". One death was re-classified from "Natural" to "Accident", due to the child having choked on food. One death was re-classified from "Natural" to "Undetermined" due to the lack of a death scene investigation.

The largest category for the manner of death was unintentional injury, which claimed the lives of 22 children in 2005. **Unintentional injury deaths are commonly referred to as accidents, both by the general public and by manner of death as recorded on death certificates. However, the term "accident" implies that the fatal injury/event could not have been prevented. Therefore, the Child Fatality Review Panel prefers the term unintentional injuries to replace the term "accident" because child deaths in this category are predictable, understandable, and preventable.**

The second largest category for the manner of death was "natural", which claimed the lives of nine children in 2005. The category "suicide" consisted of five child deaths in 2005. Two deaths were classified as homicides in 2005. The "could not be determined" category (2 deaths in 2005) includes deaths in which the manner of death cannot be conclusively categorized by the Child Fatality Review Panel after an in-depth review of the case. See the respective manner of death sections of this report for more information on each category.

Manner of Death - 2005 (N=40)



These categories will be explored further with additional data on pages 12-23 of this report.

Data Overview

Each Status A death is thoroughly reviewed by the Child Fatality Review Panel. The Panel classifies each death by the manner of death, the type of fatal injury/event, and the preventability of the death. The Panel's review of the 40 deaths determined to be "Status A" deaths, which occurred in calendar year 2005, form the basis of this report.

Demographics

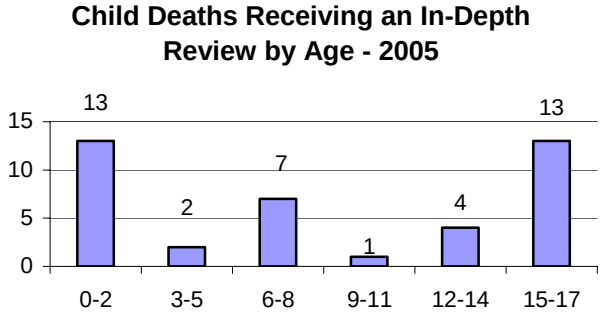
Gender of the children who died in North Dakota and received an in-depth review by the Child Fatality Review Panel.

According to the North Dakota Data Center, North Dakota's child population is nearly equally male and female (51.5% male; 48.5% female). However, 27 of the 40 (67.5%) children that died in North Dakota during 2005 were male.

Race of the children who died in North Dakota and received an in-depth review by the Child Fatality Review Panel.

According to North Dakota Kids Count for 2005, North Dakota's child population is 87% Caucasian, and 9.0% Native American. However, 11 of the 40 (27.5%) children that died in North Dakota during 2005 were Native American, indicating an over-representation of Native American Children.

The age of the children who died in North Dakota and whose deaths received an in-depth review by the Child Fatality Review Panel is reported in the chart below.



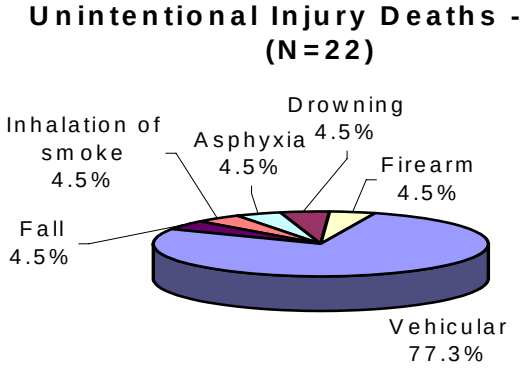
Calendar Year 2005

Unintentional Injury Deaths

All Unintentional Injury Deaths

Type of Fatal Injury/Event

There were 40 in-state child fatalities reviewed in-depth in 2005. There were twenty-two (55%) deaths categorized as unintentional injuries by the Child Fatality Review Panel. Each unintentional injury death was categorized by the type of fatal injury/event, as shown in the chart below. **By far the largest category of unintentional injury deaths is vehicular, which accounted for 17 (77.3%) of the 22 unintentional injury child deaths during 2005.** Each of the type of fatal injury/event categories for unintentional injury is examined further in this section.



Preventability of Death

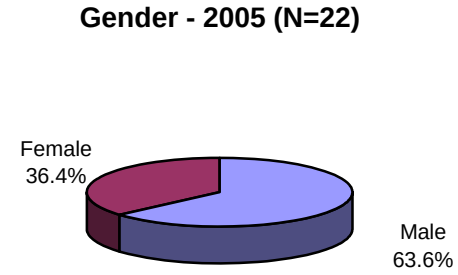
The Child Fatality Review Panel classifies each child's death as preventable or non-preventable. **Of the 22 unintentional injury deaths in 2005, all 22 were categorized as preventable. The two main reasons identified for preventable child deaths were: 1) Neglect & Reckless Conduct of Others (17 of the 22 deaths); and 2) Neglect & Reckless Conduct of the Deceased Child (13 of the 22 deaths).**

Unintentional Injury deaths are commonly referred to as accidents, both by the public and by the manner of death as recorded on death certificates. However, the term "accident" implies that the fatal injury/event could not have been prevented. Therefore, the Child Fatality Review Panel prefers the term "unintentional injury" to replace the term accident because the child deaths in this category are predictable, understandable, and preventable. In fact, the Child Fatality Review Panel classified all 22 unintentional injury deaths as preventable.

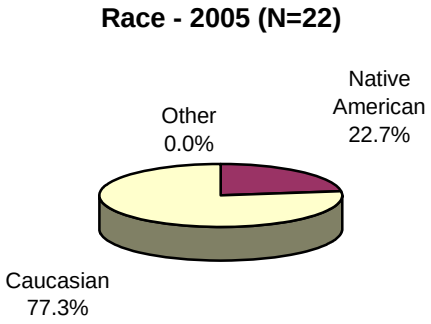
All Unintentional Injury Deaths

Demographics

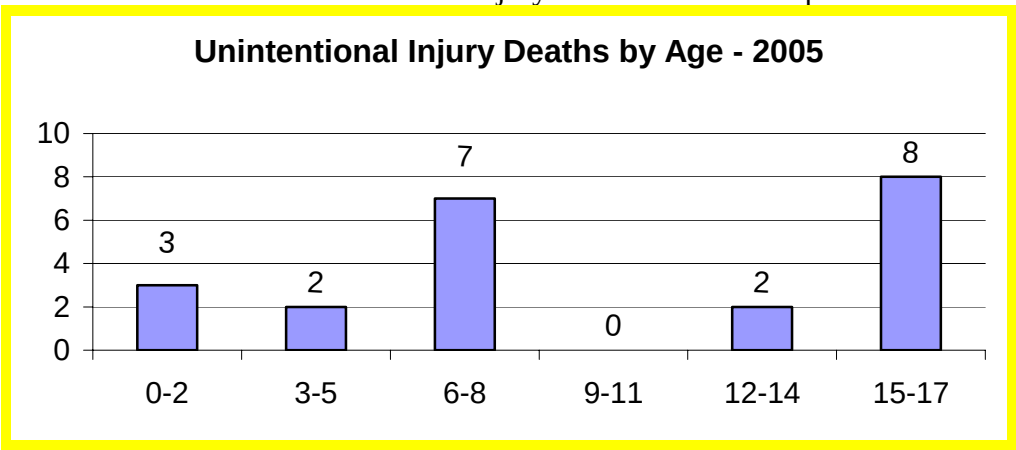
Of the 22 unintentional injury deaths in 2005, eight (36.4%) were female children compared to 14 (63.6%) male children.



In 2005, 17 (77.3%) of the children who died because of unintentional injuries were Caucasian, and five (22.7%) were Native American.



The age of the children involved in unintentional injury deaths in 2005 is reported in the chart below.

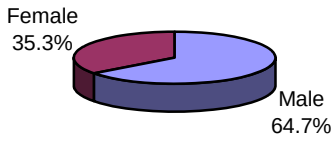


Vehicular Unintentional Injury Deaths

In 2005, 17 children died in vehicle related deaths. The Child Fatality Review Panel classified all of these deaths as preventable.

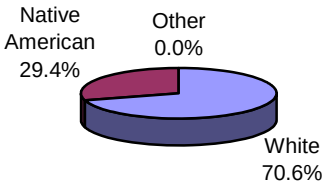
In 2005, six (35.3%) of the children who died were females compared to eleven (64.7%) males.

Gender - 2005 (N=17)

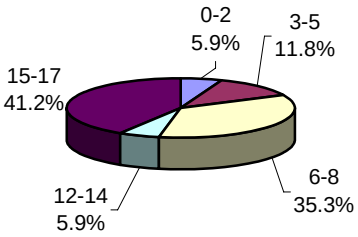


In 2005, twelve (70.6%) of the children who died were Caucasian, and five (29.4%) were Native Americans.

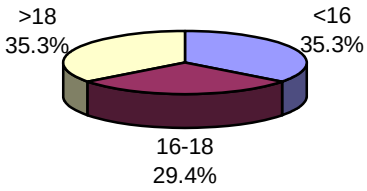
Race - 2005 (N=17)



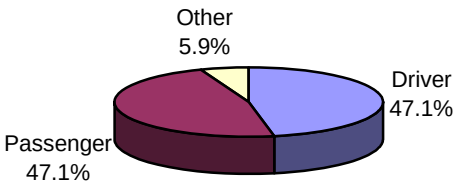
Age of Victim - 2005 (N=17)



Age of Person Driving the Deceased Child's Vehicle - 2005 (N=17)



Position of Decendent - 2005 (N=17)

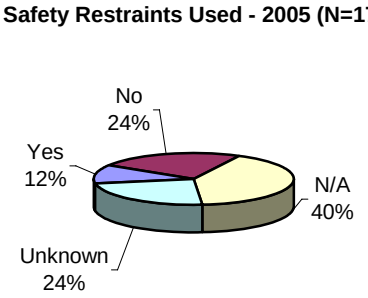


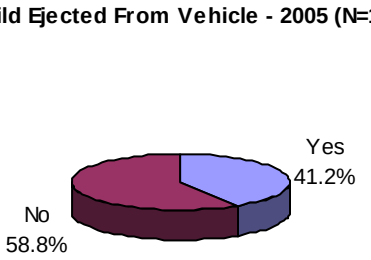
The deceased child was the driver in eight of the vehicular deaths and a passenger in eight of the deaths. One child was a pedestrian. Of the vehicular deaths in 2005, eight involved single vehicles and nine involved multiple vehicles. Of the eight deaths involving single vehicles, five were rollover crashes.

Vehicular Unintentional Injury Deaths (continued)

Safety restraints used/ Ejection from a vehicle

In the cases where use of a vehicle restraint applies, four of the children who died were not restrained. The use of safety restraints was not applicable to seven child deaths as a safety restraint would not have been required in the situation (e.g. bicycle, ATV riders, or pedestrians). The use of safety restraints is unknown in 4 of the deaths. There were six children who were ejected from the vehicle. The element of ejection did not apply in six deaths. (Ejection does not apply to vehicles that are not enclosed e.g. bicycles, ATVs, etc.). The use of a helmet applied in six of the deaths; no helmets were worn in five of these six deaths. Helmet use is unknown in one death.



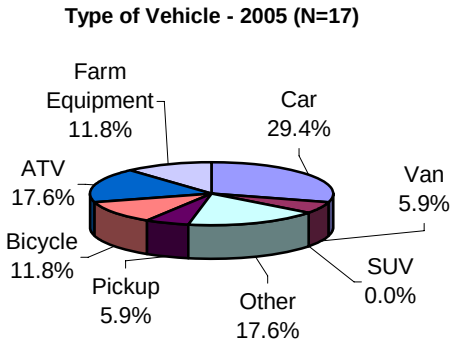


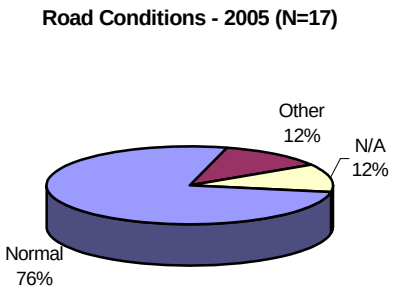
Contributing factors

Excessive speed or recklessness was a factor in three deaths. Driver intoxication was a contributing factor in one death, while underage drinking was found in two deaths. Other contributing factors include: driver distraction (6); failure to yield (4); young bicycle riders (2 - ages 4 and 6 years); young ATV drivers (2 - ages 6 and 8 years); driver inexperience (1); unlicensed driver (1, age 16); driving left of center (1); obstructed vision (1); left turn across driving lane (1). Two of the vehicle deaths were agriculture-related.

Road Conditions

The road conditions were normal in 13 deaths. Other conditions were frost (1), and ice (1) and soft shoulder (1). Two deaths occurred off a roadway.





Other Unintentional Injury Deaths

Drowning
There was one unintentional injury deaths from drowning in 2005. A six year-old Caucasian female, who had a seizure disorder, drowned in a bathtub.

Firearm
There was one child death from an unintentional firearm injury in 2005. A 14 year-old Caucasian male died when a gun discharged while hunting. The safety device on the firearm was in the "off" position.

Poisoning/Overdose
No children died from unintentional poisoning/overdose in 2005.

Asphyxia
A one year-old Caucasian male child died of asphyxia after choking on food.

Fall Injury
A sixteen year-old Caucasian male fell 100 feet from a grain silo.

Fire
A four month-old Caucasian female died from smoke inhalation when the apartment home she lived in burned.

Electrocution
No children died from unintentional electrocution in 2005.

Other Injuries
No children died with an injury categorized as "other injury" in 2005.

Calendar Year 2005

Natural Deaths

Natural Deaths Overview

Type of Fatal Injury/Event

The manner of death was classified as natural for nine (22.5%) of the 40 child deaths in 2005. One of the deaths in this category was determined by the Panel to have been preventable if an appropriate disease management plan had been in place. There was not an autopsy completed in one case of the preventable deaths. All other children in this category received an autopsy.

SIDS

Six babies died from SIDS (Sudden Infant Death Syndrome). Males accounted for five of the six deaths from SIDS. There was one female infant who died from SIDS. The race of the infants who died from SIDS was Caucasian (3) and Native American (3). Ages of the infants who died from SIDS were four months (3), five months (1), three weeks (1), and two weeks (1).

Of these six infant deaths, none were placed to sleep in an infant crib. The infants who died of SIDS were placed to sleep in unsafe infant sleep environments such as on adult beds (3); a crib mattress placed on the floor (1); a baby bouncer (1); a playpen with blankets (1). In five of the six deaths, additional risk factors for SIDS were identified, including pillows and/or blankets present in the sleep environment (3), infants placed to sleep on their side (3) or stomach (1). (One infant sleep position was unknown). Maternal drug use during pregnancy was identified in one SIDS death and illegal drugs present in the parental home were identified in one SIDS death. Present in the home of another infant was “some wire cleaners, suggestive of cleaning drug pipes, were found and leaf-like residue on some surfaces".

All of the SIDS deaths were found by the Panel to have been non-preventable. All infants who died of SIDS received an autopsy, consistent with the legal criteria for listing SIDS as a cause of death on the death certificate (NDCC 11-19.1-13. “Cause of death – Determination”).

Other Natural Deaths

During calendar year 2005, three natural deaths did not fall into one of the other identified types of fatal injury/event data categories. The following conditions led to these three child deaths:

- Cardiac Dysrythmia – A seventeen year-old Caucasian male collapsed while running for track. An autopsy was performed in this case.

- Severe hypoxic encephalopathy; Hypoxia; Asthma – A nine year-old Caucasian male, previously diagnosed with asthma, died. An autopsy was not performed in this case. The Forensic Medical Examiner was not notified.

- Acute intracerebellum hemorrhage; Vascular malformation of cerebellum. – A fifteen year-old Caucasian female was found unresponsive at home. An autopsy was performed in this case.

Calendar Year 2005

Suicide Deaths

Homicide Deaths

Deaths Where the Manner Could Not be Determined

Suicide Deaths

Suicide Deaths

There were five suicide deaths in children during calendar year 2005. The Child Fatality Review Panel classified all five deaths as preventable. Of deaths by suicide, four involved firearms and one was due to ligature hanging. All the youth in this category were male. There were two 14 year-olds, and one each 15, 16, and 17 year old. Three of the deceased children were Caucasian and two were Native American. Two of the suicide deaths were drug or alcohol related.

The table below represents the number of child deaths by suicide by year for each year the Child Fatality Review Panel has been reviewing child deaths.

Year	Suicide Deaths
1996	11
1997	7
1998	4
1999	8
2000	6
2001	5
2002	2
2003	3
2004	5
2005	5

Homicide Deaths

Homicide Deaths

In 2005, two children died as the result of homicide. Homicide deaths include a one year-old Native American female and a two month-old Caucasian female.

Of the two homicides, one resulted from a blunt force injury of the head and one resulted from asphyxia (smothering). The Panel identified that both homicides involved child abuse or neglect by the child's caregiver. The Panel determined these homicide deaths to have been preventable.

The table below represents the number of child deaths by homicide by year for each year the Child Fatality Review Panel has been reviewing child deaths.

Year	Homicide deaths
1996	0
1997	0
1998	2
1999	1
2000	1
2001	1
2002	2
2003	4
2004	3
2005	2

Deaths Where the Manner Could Not be Determined

The Panel could not determine the manner of death for two deaths in 2005. A five month-old Caucasian female was found face down in a bassinette, where the bassinette mattress was resting on magazines. Mechanical asphyxiation or other respiratory compromise from the soft bedding, wedging in a corner and stomach sleeping position could not be ruled out, even after an autopsy and a scene investigation were completed.

A two month-old Caucasian male was found unresponsive at childcare. He was taken to a hospital, where he died. An autopsy was completed, but no investigation was made of the original scene (the childcare). The child's caregiver at the time of the death was not interviewed.

The legal criteria for listing SIDS as a cause of death on the death certificate influenced the Panel's determination of the manner of death in this case. The legal criteria for listing SIDS as a cause of death on the death certificate is stated in state law, "The term "sudden infant death syndrome" may be entered on the death certificate as the principal cause of death only if the child is under the age of one year and the death remains unexplained after a case investigation that includes a complete autopsy of the infant at the state's expense, examination of the death scene, and a review of the clinical history of the infant" (NDCC 11-19.1-13 Cause of death – Determination").